Request for Access to Health Records

Applicant/Client Details

Given Name(s): _____ Surname: _____

Date of Birth: _____/_____/_____

Address: _____

Suburb: _____ Post code: _____

Email address: _____

Telephone: (Mobile)_____ (Home/Work) _____

Give permission for (please circle the relevant number, either 1, 2 or 3):

1. Better Health Network to access my health records from _____
2. Better Health Network to release my health records to _____
3. Better Health Network to release my medical records to me

Records Required:

Does this request relate to:

□ A particular service or appointment (**PART** of my health record) □ My **FULL** health record
If part of the record is required, please specify the part(s) of the record you require and indicate the dates (or best approximate) of the service: (*e.g. x-rays, test results, referrals, etc).*

_____

_____

Reason for the request:

_____

_____

Service or services that the records are being requested from:

□ All BHN Services □ GP □ Dental □ Counselling and Mental Health □ AOD □ Nursing

□ Family Violence □ NDIS □ RhED □ Pathways □ Allied Health □ ACO

□ Child Youth and Family Services □ Other: _____

Last Reviewed March 2023

If you are **NOT THE CLIENT** to whom this request relates, please complete the following section:

Given Name(s): _____ Surname: _____

Date of Birth: ___/___/_____

Address: _____

Suburb: _____ Post code: _____

Email address: _____

Telephone: (Mobile)_____ (Home/Work) _____

What is your relationship to the client? _____

Do you have the client's consent/authority to access her/his/their medical records?
□ Yes (please attach written consent/authority*) □ No

**If the application is for health records belonging to a client who is not the Applicant, the Applicant must present written consent from the client, or proof that the Applicant is the Executor of the Deceased Estate or other legal authority.*

In signing this form, the applicant agrees that:

- They are required to provide photo ID (e.g. current Driver Licence/Passport) to ensure that records are released appropriately.
- BHN may charge a fee for the work involved in providing access to documents you request (as allowed under legislation). This information will be provided when applicable, and prior to a request being processed.
- All personal information collected, stored, used, released and destroyed by BHN complies with the laws relating to confidentiality and privacy for both Victoria and Australia.

Please return the completed Application Form with the required photo ID (e.g. current Driver Licence /Passport) and other documents (if applicable) to:

Mail: Quality Manager
Better Health Network
PO Box 103
South Melbourne 3205

Email: Quality@bhn.org.au

In person: at one of our sites

Signed: _____ **Date:** _____
(Applicant's/Client's signature)

Better Health Network will notify the Applicant/Client of a decision and/or provide copies of requested documentation as soon as practicable, within 30 days of receiving the completed request.